

# Blue Direct Benefits Comparison

Traditional PPO Plans

SERVICES RECEIVED	Blue Direct \$1,000	Blue Direct \$2,000	Blue Direct \$5,000
<b>Deductible (in-network)</b>	\$1,000/member \$3,000/family	\$2,000/member \$6,000/family	\$5,000/member \$15,000/family
<b>Deductible (out-of-network)</b>	\$2,000/member \$6,000/family	\$3,000/member \$9,000/family	\$7,500/member \$22,500/family
<b>Coinsurance (in-network)</b>	20% to a max of \$3,000/member \$9,000/family	30% to a max of \$3,000/member \$9,000/family	20% to a max of \$1,000/member \$3,000/family
<b>Coinsurance (out-of-network)</b>	40% to a max of \$4,000/member \$12,000/family	50% to a max of \$4,000/member \$12,000/family	50% to a max of \$1,000/member \$3,000/family
<b>Covered Services</b>	<b>In-Network You Pay</b>	<b>In-Network You Pay</b>	<b>In-Network You Pay</b>
<b>Preventive Care</b> <i>Immunizations &amp; Screenings</i> <i>Pap Smear, Mammogram, PSA Testing</i>	Covered at 100%	Covered at 100%	Covered at 100%
<i>Routine Physical Exams, Hearing and Vision Exams</i>	\$20 per visit	\$40 per visit	Deductible & Coinsurance
<b>Other Outpatient Care</b> <i>Medical Exams and Injections</i>	\$20 per visit	\$40 per visit	Deductible & Coinsurance
<i>Lab, X-ray, Ultrasound</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<i>CT &amp; MRI scans</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<i>Physical, Occupational &amp; Speech Therapy</i>	\$20 per visit	\$40 per visit	Deductible & Coinsurance
<i>Outpatient &amp; Ambulatory Surgery</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<b>Inpatient Care</b> <i>Semi-private Room &amp; Board</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<i>Physician Services, Surgery, Anesthesia, Lab, X-ray, CT &amp; MRI scans, supplies &amp; medications, Physical, Occupational &amp; Speech Therapy<sup>1</sup></i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<i>Skilled Nursing &amp; Physical Rehab Facility (limited to 100 inpatient days per member/year for each facility)</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<b>Emergency Room Services</b> <i>ER Physician, CT &amp; MRI scans, medical supplies, etc.</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<i>ER Charge</i>	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	Deductible & Coinsurance
<b>Durable Medical Equipment</b> <i>(limited to \$3,000 per member/year)</i>	\$100 DME Deductible 30% Coinsurance	\$100 DME Deductible 30% Coinsurance	\$100 DME Deductible 30% Coinsurance
<b>Mental Health &amp; Substance Abuse<sup>2</sup></b> <i>Outpatient Visit</i>	\$20 per visit	\$40 per visit	Deductible & Coinsurance
<i>Inpatient Services</i>	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
<b>Prescription Drugs</b> <i>\$100 Deductible per member per calendar year (Deductible does not apply to generic drugs.)</i>	\$10/\$25/\$40 copay	\$10/\$25/\$40 copay	\$10/\$25/\$40 copay
<b>Prescription Drug Maximum<sup>3</sup></b>	\$2,000 max/member	\$2,000 max/member	\$2,000 max/member
<b>Lifetime Maximum Benefit<sup>3</sup></b>	\$2 million/member	\$2 million/member	\$2 million/member

<sup>1</sup> Physical, occupational and speech therapy limited to \$3,000 per member/year

<sup>2</sup> Inpatient and outpatient services subject to combined \$3,000 per member/year and \$10,000 per member/lifetime maximums

<sup>3</sup> Stated maximums are applicable to in-network and out-of-network combined